California Academy of Family Physicians

# POLICY COMPENDIUM

## Ethics Policies

CAFP
California Academy of Family Physicians

# ETHICS

This section contains policy about ethics. This includes artificial intelligence, minors and confidentiality, criminal justice and law enforcement, end of life care, liability, and physician autonomy.

## 50.01 Artificial Intelligence (AI)

**Ethical Application of AI in Family Medicine**

CAFP supports regulation and review of applied artificial intelligence and machine learning in healthcare based on the Principles of Ethical Application of Artificial Intelligence in Family Medicine set forth by the AAFP. *(BoD 7/2024)*

Medical Practice Affairs Committee (MPAC) is charged with regularly reviewing and to recommend policy and action to address rapid changes in technology implementation. *(BoD 7/2024)*

**AI Policy Principles**

The following is a summary of CAFP's AI Policy Principles. For more detailed information, please see our Policy Reference Report on Artificial Intelligence here or on CAFP's website at www.familydocs.org/policy.

1. If AI tools are utilized, the patient-physician relationship must be preserved and enhanced. When AI is applied to primary care, it must enhance the 4 C's of primary care (first contact, comprehensiveness, coordination, and continuity) and expand primary care's capacity and capability to provide longitudinal care that achieves the quintuple aim.
2. Maximize transparency, including that of patient data (e.g. usage and storage), sourcing of medical recommendations, and assumptions used to train the models, algorithms and limitations.
3. Require processes in place to identify and mitigate implicit bias within AI models from learning those same biases. As appropriate, AI should have a process for monitoring and remediating for differential outcomes, particularly those that affect vulnerable patient populations.
4. Maximize training data diversity so that it is representative of the populations cared for by family medicine.
5. Provide clear policies around how AI developers collect, store, use and share data from patients and end-users as well as identify what data is not covered by appropriate laws and regulations. Developers must get consent for collecting any identifiable data and the consent should clearly state how the data will be used or shared.
6. Take a systems view in design that aligns with user-centered, real-world workflows and maintains rigorous quality assurance processes. AI should support clinical care only when chosen by patients and physicians.

7. AI solutions should assume appropriate liability and undergo rigorous evaluations as any other medicine intervention, including research-based demonstration of efficacy.
8. Design for trustworthiness by ensuring developers have the highest levels of safety, reliability and accuracy in their AI solutions.
9. Research and evaluation should include family physician input on potential harms and benefits in patient care, including automation bias, reduced information integrity, safety concerns, and implications for privacy and security. Research and evaluation data should be shared and include an assessment of AI's broader societal impacts. *(BoD, 12/2025)*

## 50.02 Confidentiality for Minors

**Minors and Confidentiality**

Minors have the right of confidentiality in the areas of contraception, pregnancy, STDs and physical and/or sexual abuse in accordance with the following AAFP policy statement and the Joint Statement of the AAFP, the ACOG, the American Academy of Pediatrics, the Organization for Obstetric, Gynecologic and Neonatal Nurses, and the National Medical Association. *(CoD 2/2000)*

"One must attempt to achieve a balance between the rights of the parents and what is necessary to maintain and promote the health and well-being of the adolescent. It is proper and ethical for the family physician to protect an adolescent's confidentiality. Withholding information from third parties, including parents, may be appropriate when it pertains to but is not limited to contraception, pregnancy, sexually transmitted diseases and physical and/or sexual abuse by a parent. Parental involvement, consent, or notification should not be a barrier to care for the adolescent." (Paragraph 55 of the report of the Commission on Special Issues and Clinical Interests – "Adolescent Health Care—Confidentiality" Adopted 1994:243-244; 347.

"Adolescents tend to under-utilize existing health care resources. The issue of confidentiality has been identified by both providers and young people themselves, as a significant access barrier to health care.

Adolescents in the United States, while generally considered healthy, have a range of problems, including some of such severity as to jeopardize their development and health, their future opportunities, and even their lives. To illustrate, there is an urgent need to reduce the incidence of adolescent suicide, substance abuse, and sexually transmitted diseases and unintended pregnancy.

As the primary providers of health care to adolescents, we urge the following principles for the guidance of our professional members and for broad consideration in the development of policy:

1. Health professionals have an ethical obligation to provide the best possible care and counseling to respond to the needs of their adolescent patients.

2. This obligation includes every reasonable effort to encourage the adolescent to involve parents, whose support can, in many circumstances, increase the potential for dealing with the adolescent's problems on a continuing basis.
3. Parents are frequently in a patient relationship with the same providers as their children or have been exercising decision-making responsibility for their children with these providers. At the time providers establish an independent relationship with adolescents as patients, the providers should make this new relationship clear to parents and adolescents with regard to the following elements:
    a. The adolescent will have an opportunity for examination and counseling apart from parents, and the same confidentiality will be preserved between the adolescent patient and the provider as between the parent/adult and the provider.
    b. The adolescent must understand under what circumstances (e.g., life-threatening emergency), the provider will abrogate this confidentiality.
    c. Parents should be encouraged to work out means to facilitate communication regarding appointments, payment, or other matters consistent with the understanding reached about confidentiality and parental support in this transitional period when the adolescent is moving toward self-responsibility for health care.
4. Providers, parents, and adolescents need to be aware of the nature and effect of laws and regulations in their jurisdictions that introduce further constraints on these relationships. Some of these laws and regulations are unduly restrictive and in need of revision as a matter of public policy. Ultimately, the health risks to the adolescents are so impelling that legal barriers and deference to parental involvement should not stand in the way of needed health care." *(CoD 2/2000)*

**Patient Protection of Information from Adverse Childhood Experiences (ACEs) Screening**

CAFP support the collection of information from the ACEs screening be subject to pre-existing conditions protections for health insurance. Adverse Childhood Experience (ACE) scores be used as a screening tool, not diagnostic of the implied risk condition. *(BoD 5/2020)*

## 50.03 Criminal Justice and Law Enforcement

**Criminal Prosecution of Physicians for Medical Acts**

CAFP opposes: 1) the criminal prosecution of physicians for acts committed within the scope of their professional conduct, for which there is no criminal intent; and 2) opening peer review records for criminal cases because it may have a chilling effect on medical expert's willingness to testify in court and could destroy a valuable process for finding and fixing health care problems quickly. *(BoD 2/1998)*

CAFP opposes the criminalization of medical practice and opposes legislation that allows the federal government to define appropriate medical practice and regulate such practice through the use of criminal penalties. *(CoD 3/2008)*

**End Police Brutality and Reinvest in Public Health**
CAFP advocate for diversion programs and community alternatives to incarceration including

- that law enforcement agencies should adopt and enforce policies prohibiting profiling and discrimination based on race, ethnicity, national origin, religion, age, gender, gender identity/expression, sexual orientation, immigration status, disability, housing status, occupation, and language fluency,
- the universal adoption of evidence-based de-escalation techniques and the use of the lowest level of force when force becomes necessary to maintain safety,
- investing in community resources, including schools, childcare and youth programs, safe and affordable housing, fair wages, food pantries, specialized case workers and first responders, mental health workers, including programs that use crisis workers with mental health training to respond to emergency calls.

# Topic: mental health

CAFP support legislation that improves access to health care upon release from prison or jail.

CAFP advocate for sustainable investment in comprehensive mental health services that include long-term treatment and care.

CAFP advocate for sustainable funding to provide clinical services for people with serious mental illnesses and substance use disorders, including those who need mental health services upon release from a correctional facility. *(BoD 11/2022)*

**Health Care for Formerly Incarcerated Persons**
CAFP support efforts to improve access to health care for formerly incarcerated persons following their release; and be it further

CAFP support increased funding for evidence-based programs designed to meet the needs of people recently released from incarceration. *(BoD 7/2019)*

**Improved Quality of Reproductive Health for Incarcerated People**
CAFP advocate for improved access to timely but non-coercive abortion for incarcerated people in California, and improved accountability of correctional facilities in complying with existing reproductive health law. *(BoD 9/2020)*

**Oppose Forced Sterilization and Contraceptive Coercion of Incarcerated and Detained Individuals**
CAFP will work with AAFP to advocate for public transparency of the investigation of allegations of forced sterilizations in detention centers and for policies that prevent contraceptive coercion.

# Topic: reproductive health, contraception

**Protect Patients from Extremist Groups in Policing**
CAFP oppose affiliation with hate groups or participation in public expressions of hate or violence by law enforcement officials. *(BoD 11/2021)*

**Reporting of Injuries Resulting from Law Enforcement Actions**
CAFP support the creation of a process for Family Physicians to report injuries sustained from law enforcement agents, and be it further

CAFP provides education to Family Physicians in California on the established process for Family Physicians to report injuries sustained from law enforcement agents and the care of patients who sustain such injuries. *(BoD 11/2021)*

## 50.04 End of Life Care

**Patient-Centered End of Life Care**
CAFP recognizes the need for appropriate end-of-life care, which may include:

- Appropriate treatment of physical pain, recognizing that in some cases such treatment may hasten the end of life;
- Compassionate care which is interpersonal, existential or spiritual, and may include working together with social workers, hospice, clergy, family and friends; and
- Eliciting and addressing a patient's reasons for considering physician aid-in-dying.

Only through dialogue can family physicians, their patients and society as a whole continue to explore what is reasonable and morally appropriate. The highest-quality health care is an outgrowth of a partnership between the patient, the family and the health professional or professional team.

Within the context of this continuing relationship, family physicians must seek the underlying causes of suffering at the end of life, and then aggressively implement measures to correct them. Appropriate education in palliative care and medical management, advanced communication skills to discover the patient's wishes and value choices, and appropriate sharing of decision-making with the patient and the patient's family can go a long way toward alleviating suffering and improving care at the end of life. Family physicians should continue to provide assistance in dealing with dying patients' symptoms, needs and fears. *(BoD 4/2015)*

**Medical Aid-in-Dying Is Not "Assisted Suicide"**
CAFP rejects the term "assisted suicide" to describe the process whereby terminally ill patients of sound mind ask for and receive prescription medication they may self-administer to hasten death should their suffering become unbearable, and be it further

CAFP acknowledges that use of medical aid in dying is an ethical, personal end-of-life decision that should be made in the context of the doctor-patient relationship, and be it further

CAFP recognizes medical aid-in-dying as an ethical end-of-life option when practiced where authorized and according to prescribed law. *(BoD 11/2017, updated 9/2026)*

**POLST Registry**
CAFP support development of a state-wide electronic Physician Orders for Life Sustaining Treatment (POLST) registry. *(BoD 6/2021)*

**Supporting End of Life Autonomy and Improving the Aid in Dying Process**
CAFP reaffirms its values of respecting patient autonomy and the doctor-patient relationship in regards to end of life care, and be it further

Medical aid in dying continues to represent a viable option for patients of sound mind who are experiencing terminal suffering and who have been informed of all their options, and be it further

CAFP supports the ability of terminally suffering patients to have access to medical aid in dying services including telemedicine, and be it further

CAFP supports a reduced waiting period for patients to access medical aid in dying, as is available in other states. *(BoD 7/2021)*

## 50.05 Liability

**Ensuring Confidential Peer Review**
CAFP adopt as its policy that, in the public interest, peer review activities by medical staffs, medical societies, medical groups, health plans and other entities should be confidential, protected and not subject to disclosure by administrative subpoena;

CAFP supports appropriate introduced state legislation that will prevent disclosure of peer review be administrative subpoena; and CAFP communicate and cooperate with the California Medical Association to establish common peer review confidentiality policy. *(CoD 2/1997)*

**Malpractice Coverage for 'High Risk' Providers**
CAFP supports the development of statewide solutions to lower or completely cover the cost of malpractice coverage for clinicians offering critical reproductive health services – which include but are not limited to maternity care, abortion, and gender-affirming services – in underserved areas of California and for clinicians offering these services under the state's shield laws as interstate telehealth medical clinicians. *(BoD 11/2024)*

CAFP supports exploring options for a state based malpractice coverage, similar to the Federal Tort Claims Act. *(BoD 11/2024)*

**Medical Injury Compensation Reform Act (MICRA)**
CAFP supports the preservation of MICRA and opposes legislative proposals intended to weaken MICRA. *(BoD 6/1992)*

**Periodic Payments**
Support legislation that would eliminate periodic payments for non-economic losses and physician liability for periodic payments relating to economic losses. Continue to deep malpractice premiums affordable by defending the structure of, and cap on MICRA. Maintain the quality of peer review by ensuring the protection against liability of those physicians who participate in peer review. *(BoD 5/1998)*

**Preserve MICRA**
Develop a policy statement, action plan and designate a spokesperson to represent CAFP's interests in tort reform issues, including the preservation of MICRA. *(BoD 10/1994)*

## 50.06 Clinician Autonomy

**Conscientious Objection and Right to Withdrawal**
No physician shall be compelled to perform any act which violates his/her good judgment or personally held moral standards. In these circumstances, the physician may withdraw from the case so long as the withdrawal is consistent with good medical practice. *(COD 2/1993)*
# Topic: reproductive health, abortion

**Personal Moral Objections in Clinical Practice**
Support the concept that no physician or other health professional shall be required to perform any act violative of personally held moral principles. *(CoD 1/1995)*
# Topic: reproductive health, abortion

**Pharmacists' Conscience Clause**
CAFP believes that a pharmacist's right of conscientious objection to filling a specific prescription should be reasonably accommodated, but to safeguard the physician-patient relationship, governmental policies must be in place to protect patients' rights to obtain legally prescribed and medically indicated treatments. *(BoD 11/2005)*
# Topic: prescription drugs

**Political Interference in Medical Decision Making**
CAFP opposes political interference in the medical decision-making processes for any individual patient. *(BoD 4/2005)*